DEPARTMENT OF FINANCE

ARNOLD SCHWARZENEGGER, GOVERNOR

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December 1, 2008

Honorable Denise Moreno Ducheny, Chair
Senate Budget and Fiscal Review Committee

Honorable Noreen Evans, Chair
Assembly Budget Committee

Honorable Christine Kehoe, Chair
Senate Appropriations Committee

Honorable Kevin DeLeon, Chair
Assembly Appropriations Committee

Final Report—California Department of Mental Health, State Hospital System Budget Estimates Audit

Pursuant to the 2008-09 Budget Act, the Department of Finance, Office of State Audits and Evaluations, has completed its audit of the California Department of Mental Health's (DMH) state hospital system budget estimates.

The DMH agreed with our observations and their response is incorporated into this final report. We appreciate the assistance and cooperation of the DMH and their willingness to research and implement corrective actions. In accordance with Finance's policy of increased transparency, this report will be placed on our website.

If you have any questions regarding this report, please contact Susan M. Botkin, Manager, or Rick Cervantes, Supervisor, at (916) 322-2985.

Sincerely,

David Botelho, Chief
Office of State Audits and Evaluations

cc: On following page

cc: Mr. Stephen W. Mayberg, Ph. D., Director, California Department of Mental Health
Ms. Elaine Bush, Chief Deputy Director, California Department of Mental Health
Mr. Sean Tracy, Chief, Strategic Planning and Policy, California Department of Mental Health
Mr. Stan Bajorin, Deputy Director, Administration, California Department of Mental Health
Ms. Cynthia Radavsky, Deputy Director, Long Term Care Services, California Department of Mental Health
Ms. Jeannie Barawed, Assistant Deputy Director, Long Term Care Services, California Department of Mental Health
Mr. David Harner, Chief Program Policy and Fiscal Support, Long Term Care Services, California Department of Mental Health
Ms. Vallery Walker, Internal Auditor, Office of the Director, California Department of Mental Health

BUDGET ESTIMATES AUDIT

California Department of Mental Health
State Hospital Budget Estimate Review

Source: California Department of Mental Health, "Coalinga State Hospital Main Courtyard"

Prepared By:
Office of State Audits and Evaluations
Department of Finance

094440007DIR

November 2008

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Table of Contents

Executive Summary

The California Department of Mental Health (DMH) operates five state hospitals throughout California. Each state hospital provides inpatient treatment services for Californians with serious mental illnesses. Pursuant to the 2008-09 Budget Act and an Interagency Agreement with the DMH, the Department of Finance, Office of State Audits and Evaluations (Finance), conducted an audit of DMH's state hospital budget estimation process.

The DMH uses a regression analysis formula of patient census and historical costs to project anticipated patient caseloads and expenditures. The projected patient caseloads and expenditures are used to prepare the Governor's Budget and May Revision. The following observations were noted:

- The methodology for estimating patient case load and level-of-care personal services appears to be reasonable and adequately supported.
- The methodology for estimating operating expenditures appears to be reasonable and adequately supported.
- Coalinga State Hospital operating expenditures were not included in the 2008-09 budget year projection.
- Hospital expenditures are adequately monitored.

Other matters outside the scope of this audit came to our attention that significantly impact hospital quality of care, employee morale, and cost of care. These issues should be considered to improve hospital operations:

- The current staffing model may not adequately reflect hospital work load.
- The equity pay increases resulting from the Coleman, Plata and Perez lawsuits have not been incorporated into the budgeted overtime allocations.
- Funding is insufficient for annual operating expenditures.

Additionally, the development and implementation of corrective actions for the hospital budget process audit findings identified in Finance's December 2007 report should continue.

BACKGROUND, SCOPE, AND METHODOLOGY

BACKGROUND

The California Department of Mental Health (DMH) leads the state's mental health system, ensuring the availability and accessibility of effective, efficient, and culturally competent mental health services. DMH's Long Term Care Services (LTCS) Program has a $1.3 billion budget that includes the five state hospitals: Atascadero (ASH), Coalinga (CSH), Metropolitan (MSH), Napa (NSH), and Patton (PSH). Each hospital is staffed by professionally trained clinicians and administrative support teams who provide full-time inpatient care to the most serious mentally ill and those incapable of living in the community. These referrals come from county mental health departments, the courts, and the Department of Corrections and Rehabilitation (CDCR).

The patients served are often classified on the basis of the legal class or type of commitment proceeding that resulted in their placement in a state hospital. There are two basic types of commitments to state hospitals: patients may be committed as a danger to self or others, or gravely disabled, under civil statutes commonly referred to as Lanterman-Petris-Short (LPS) commitments; or they may receive a Judicially Committed/Penal Code commitment from the courts, Board of Prison Terms, or CDCR, these patients are known as forensic patients.

The cost of caring for various categories of forensic patients is generally supported from the State General Fund. Counties reimburse the state hospitals using funds that they receive from the state under the 1991 state-local realignment of tax revenues and mental health program responsibilities. Approximately 90 percent of occupied beds are now utilized for forensic patients while about 10 percent are purchased by the counties.

- The DMH's LTCS Program has experienced a tremendous growth in the patient population (20 percent increase in 5 years) and patient level of care treatment. This growth has significantly impacted DMH's operating costs. DMH's average total cost per patient (including personal services and operating expenditures) in 2003-04 was $144,798 and increased to $194,732 in fiscal year 2007-08 (Table 1). The growth has been driven primarily by new laws, regulations, and equity pay adjustments as well as recent reviews by regulatory agencies[1]. Over five years, the average cost per patient has increased approximately 34 percent. Two thirds of the patient care cost increases occurred in personal services. The average personal services cost per patient increased $33,260, from $123,468 (2003-04) to $156,728 (2007-08). Increases in personal services costs were primarily due to the equity pay increases resulting from the Coleman, Plata, and Perez lawsuits and the Civil Rights of Institutionalized Persons Act (CRIPA Enhancement Plan). The other drivers for DMH's operating costs were primarily outpatient medical care, medical consultants, food, and pharmaceuticals (Table 8).

[1] See Appendix A for details relating to the DMH's legal challenges resulting in increased costs to the state hospitals.

Table 1: 2003-04 to 2007-08 Cost Per Patient					
	FY 2003-04	FY 2004-05	FY 2005-06	FY 2006-07	FY 2007-08
Total Expenditures	$640,439,838	$697,561,964	$793,878,175	$898,723,843	$1,035,389,324
Census at June 30th	4,423	4,907	5,002	5,183	5,317
Cost per patient	$144,798	$142,157	$158,712	$173,398	$194,732

Source: DMH Patient Census Data and Expenditure Reports

SCOPE

The Department of Finance, Office of State Audits and Evaluations (Finance) was directed to perform a review of DMH's state hospital budget estimate system, including the projection of patient caseload categories and operating expenditures. Additionally, the objectives of this review included a review of marginal costing information used for this population. Inquiries were also made to state hospital systems outside of California to identify other budgeting methodologies. This review is limited to the five state hospitals; ASH, CSH, MSH, NSH, and PSH. The two acute psychiatric programs at the California Medical Facility and the Salinas Valley State Prison were not included in our review.

While observations 6 and 7 are outside the scope of this audit, they were included in this report because of their significant impact on personal services and operating expenditures.

For informational purposes an update of DMH's corrective action plan as it relates to the hospital budget process findings from the 2007 Internal Control Review was obtained.

METHODOLOGY

To evaluate DMH's state hospital budget estimates, interviews were conducted with the following entities: DMH's LTCS Division, ASH, CSH, MSH, NSH, PSH, California Department of Developmental Services, the Pennsylvania Department of Public Welfare, Bureau of Community and Hospital Operations, and the Texas Department of State Health Services, Mental Health and Substance Abuse Division. Topics discussed included:

- Budget methodology and allocation
- Patient census data
- Operating expenditures
- Level of care (LOC) and non-LOC personal services
- Implementation of state hospital changes per the CRIPA Enhancement Plan

Additional steps performed to meet the audit objectives:

- Review the budget methodology and allocation
- Review patient census data calculations used to prepare the Governor's Budget and the May Revision
- Compare budgeted appropriations to actual expenditures
- Perform analytical reviews of personal services and operating expenditures
- Compare other state hospitals budget methodology to DMH

In order to meet our objectives we relied upon interviews and inquiry of DMH staff. We did not evaluate documents and reports received from the DMH for validity. However, nothing came to

our attention that led us to believe the information provided was unreliable or misstated. Our review and analysis of personal services data was primarily limited to LOC as it is directly related to the patient caseload projections.

Recommendations were developed based on our review of documentation made available to us, our observations, and interviews with the management and key staff directly responsible for developing budget estimates. This review was conducted during the period July 2008 through October 2008.

The review was conducted in accordance with *Government Auditing Standards*, issued by the Comptroller General of the United States. In connection with this review, there are certain disclosures required by *Government Auditing Standards*. Finance is not independent of the DMH, as both are part of the State of California's Executive Branch. As required by various statutes within the California Government Code, Finance performs certain management and accounting functions. These activities impair independence. However, sufficient safeguards exist for readers of this report to rely on the information contained herein.

The California Department of Mental Health (DMH) patient caseload projections and the level-of-care (LOC) personal services[2] methodology are reasonable, the calculations are accurate, and the data is supported. DMH's operating expenditures budget methodology is reasonable. The calculations and expenditures information supporting budget change proposals are generally accurate. Moreover, the hospitals and DMH headquarters monitor operating expenditures to prioritize spending and prevent deficits. The following observations were identified:

Observation 1: Acceptable Patient Caseload Projection and LOC Personal Services Estimation Methodology

DMH's patient caseload projection and LOC personal services estimation methodology and calculations were properly supported. The regression analysis methodology was reviewed and the census data used to project patient caseloads was supported by hospital census reports and reasonably estimated patient populations. The schedules for authorized LOC positions were supported by adequate documents. Also, the LOC staffing ratio sheets were reviewed and significant variances were not found. Moreover, DMH incorporates a current year adjustment factor to correct patient caseload projection variances exceeding 2.5 percent. DMH's patient caseload projection and LOC personal services estimation methodology is a reasonable budgeting methodology.

Observation 2: Acceptable Operating Expenditures Estimation Methodology

DMH's operating expenditures estimation methodology and calculations were properly supported, calculated, and reasonably estimated expenditures. Expenditures for the past three years are used by the DMH to perform a straight-line regression analysis to project expenditures for the budget year. The difference between the current year expenditures and the projected budget year expenditures is generally DMH's requested adjustment for the budget year. The regression analysis methodology for 2003-04 to 2008-09 was reviewed and DMH's calculations were supported by accounting reports, were correct, and reasonably estimated actual expenditures. DMH's regression methodology is a reasonable tool to estimate future expenditures. However, the methodology should be revised to include Coalinga State Hospital's (CSH) operating expenditures (Observation 3).

Observation 3: CSH Operating Expenditures Were Not Included In DMH's 2008-09 Projection

DMH's calculations to estimate operating expenditures for 2008-09 did not include CSH operating expenditures. CSH was a new facility in activation and the patients were primarily

[2] See Appendices B and C for DMH's personal services budget estimation and patient caseload methodology.

transfers from Atascadero State Hospital (ASH). The DMH appropriately excluded CSH operating expenditures from the projections through budget year 2007-08, because DMH had submitted a separate budget change proposal for CSH. For budget year 2008-09, DMH did not submit a separate budget change proposal for CSH operating expenditures. Also, as of June 30, 2008, most of ASH's Sexually Violent Predator patients had been transferred to CSH. CSH new admissions currently consist of patients admitted from outside the state hospital system. Budget for estimates for 2008-09 should have included CSH expenditures to better reflect the future operating expenditures.

Observation 4: Reasonable Allocation of Operating Expenditures Funds

DMH's allocation of operating expenditures funds to the five hospitals is reasonable, consistent, equitable, and properly documented. Available operating expenditures funds (net of funds set aside for headquarters and special projects) are allocated to hospitals based on their actual census. The annualized patient operating expenditures (available operating expenditures funds divided by the budgeted patient population) is multiplied by the hospital's actual census. The annual operating expenditures allocations are documented in memorandums distributed to the hospitals. The initial allocation is sent to the hospitals after the budget is enacted. Subsequent allocations occur during the current year for adjustments to operating expenditures funds (e.g. population changes at the hospitals). State hospital systems in Pennsylvania and Texas use similar methodologies to allocate operating expenditures funds. The California Department of Developmental Services allocates operating expenditures funds by patient populations, base amounts, and facility square footage.

Observation 5: Adequate Monitoring of Operating Expenditures

Operating expenditures are adequately monitored at DMH headquarters and the hospitals. DMH does not allocate all of the operating expenditures funds to hospitals. A portion is set aside for system-wide projects, projected census growth, special projects, and reserves for unanticipated expenditures (e.g. implementing the CRIPA Enhancement Plan recommendations). DMH monitors operating expenditures and releases reserves to hospitals in subsequent allocations based on necessity. DMH's procedures help prevent deficits. Moreover, the DMH can use the reserves and unspent hospital funds to pay for major unanticipated emergency repairs.

After the initial allocation, each hospital prepares a detailed budget. Hospital executive management work with departmental managers to allocate funds to specific departments and expenditure line items. The hospitals monitor their expenditures and periodically send detailed reports to DMH. Allocation of funds at the hospital level is appropriate because each hospital has a unique location, patient population, and facility. These factors impact hospital operations; management at the local level can best address their funding needs.

Recommendation:

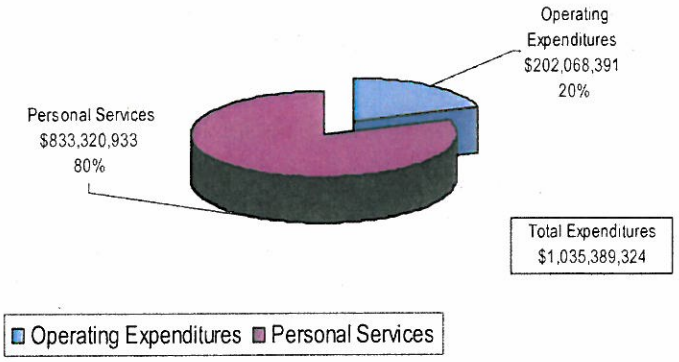
- Include CSH operating expenditures in the straight-line regression analysis used to estimate budget year operating expenditures.

Other matters outside the scope of this audit came to our attention that could significantly impact hospital quality of care, employee morale, and cost of care. For example, excessive overtime and performance of tasks not directly related to patient care by LOC staff. These issues should be considered to improve hospital operations:

Observation 6: Current Staffing Model May Not Adequately Reflect Hospital Work Load

These issues are related to the current staffing model. Any improvement to the staffing model could help improve hospital operations and reduce personal services expenditures that totaled $833 million in 2007-08 (Table 2). The issues discussed below were concerns presented by all the hospitals. However, these issues were outside the scope of this audit and were not evaluated.

Table 2: 2007-08 State Hospitals' Expenditures



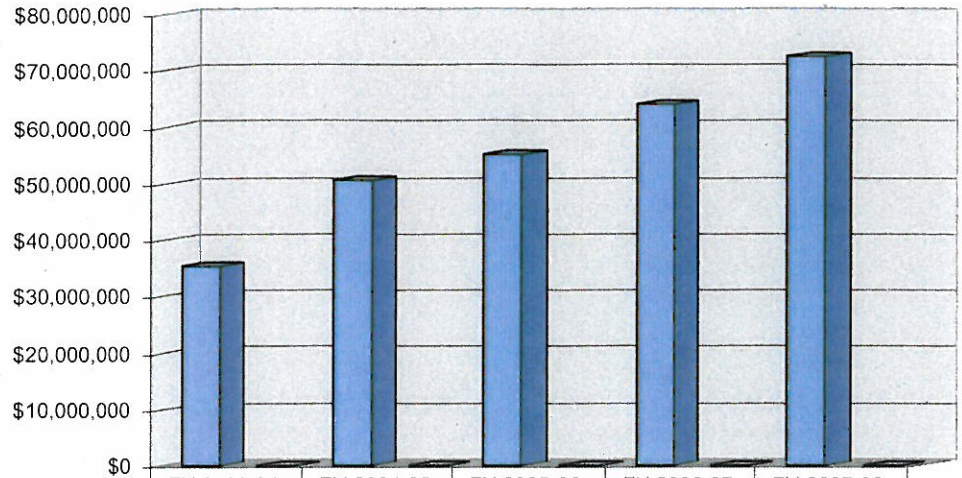
Source: DMH State Hospital Expenditure Reports

- The hospitals are concerned with the current LOC workload. The hospitals cited changes in patient treatment as a significant impact to workload. Most of the patient treatment changes are the result of changes in patient demographics as well as the Civil Rights of Institutionalized Persons Act (CRIPA) Enhancement Plan. For example, the CRIPA Enhancement Plan has increased requirements for training, monitoring, and patient services. This increased workload may not have been correctly reflected in the staffing ratios. Moreover, the hospitals were concerned that level of care (LOC) staff are currently performing administrative functions that could be performed by non-LOC staff. Workload shifted to lower paid non-LOC staff could result in costs savings.

- The LOC staffing ratios used to prepare the budget estimates were above the CRIPA Enhancement Plan ratio requirements. According to the DMH, the CRIPA Enhancement Plan and licensing requirements ratios are minimum standards. DMH uses higher staffing ratios to meet patient care needs. The minimum staffing ratios do not account for patients that require a higher level of care. For example, a patient on suicide watch requiring one-to-one supervision would exceed the minimum staffing ratio.

- Overtime expenditures at the state hospitals have increased 105 percent, from $35.4 million in 2003-04 to $72.7 million in 2007-08 (Table 3). Furthermore, the average overtime cost per patient has increased approximately 71 percent, from $8,010 to $13,665. The increase is partially attributable to staffing requirements under the CRIPA Enhancement Plan, vacancies, training, and salary increases.

Table 3: 2003-04 to 2007-08 Overtime Expenditures Per Patient



	FY 2003-04	FY 2004-05	FY 2005-06	FY 2006-07	FY 2007-08
Total Overtime	$35,427,828	$50,497,571	$55,280,316	$64,077,027	$72,657,958
Census at June 30th	4,423	4,907	5,002	5,183	5,317
Average Per Patient	$8,010	$10,291	$11,052	$12,363	$13,665

Source: DMH State Hospital Expenditure Reports

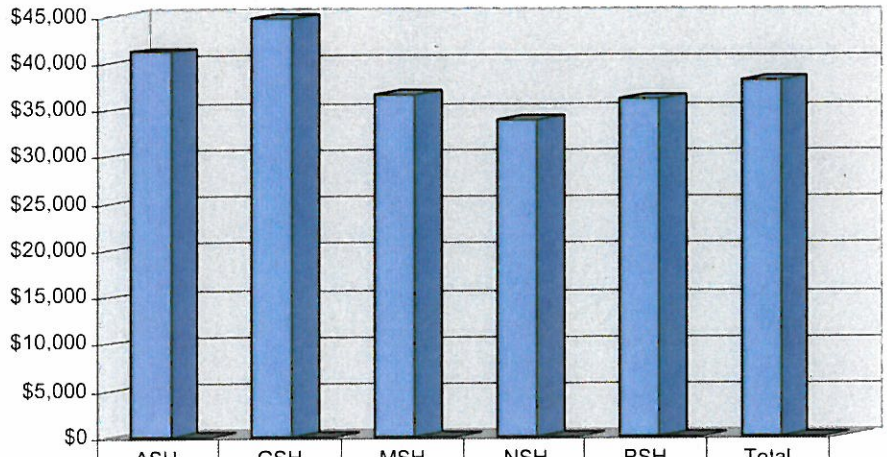
- DMH's personal services budget for overtime does not include the equity pay increases resulting from the Coleman, Plata and Perez lawsuits. Currently, salary savings generated by vacancies have been sufficient to cover overtime. However, deficiencies may occur in the future if overtime is not adjusted in the DMH budget.

Observation 7: Funding is Insufficient for Annual Operating Expenditures

Cost savings from personal services are used to offset operating expenditures. The annualized per patient operating expenditures funding for 2007-08 was $21,525[3] and actual expenditures were $38,004 (Table 4), resulting in $16,479 deficiency per patient. Moreover, there has been a deficiency in operating expenditures for 2003-04 to 2007-08. The deficiency increased from $6 million to $68.3 million for 2003-04 and 2007-08, respectively (Table 5). These deficiencies have been offset by personal services savings (Table 5). Total operating expenditures increased to $202.1 million (2007-08) and the net savings decreased to $2.9 million in 2007-08 (Table 5).

[3] Source: DMH's Expenditure Allocation Memorandum.

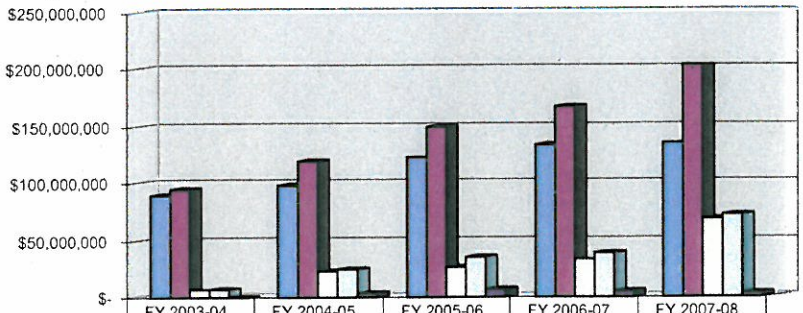
Table 4: 2007-08 Operating Expenditures Per Patient



	ASH	CSH	MSH	NSH	PSH	Total
Average per Patient	$41,148	$44,831	$36,592	$33,929	$36,023	$38,004
Census at June 30, 2007	1,148	768	681	1,195	1,525	5,317

Source: DMH State Hospital Expenditure Reports

Table 5: 2003-04 to 2007-08 Operating Expenditures (OE) and Salary Savings

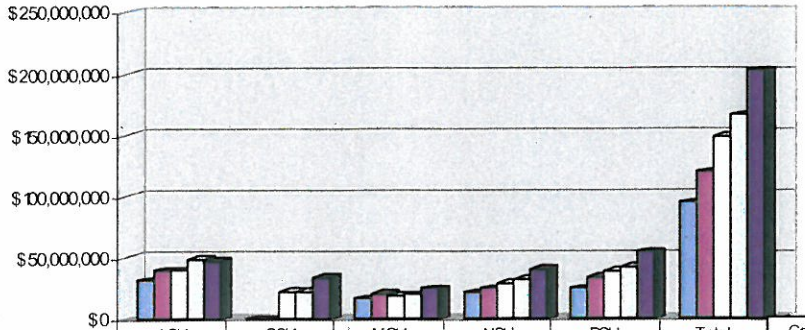


	FY 2003-04	FY 2004-05	FY 2005-06	FY 2006-07	FY 2007-08
Budgeted OE Total	$88,386,285	$97,219,267	$121,602,204	$133,429,146	$133,745,884
Actual OE Total	$94,339,106	$119,162,926	$148,397,944	$165,548,059	$202,068,391
OE Overruns	($5,952,821)	($21,943,659)	($26,795,740)	($32,118,913)	($68,322,507)
Salary Savings	$6,770,323	$24,581,472	$34,219,544	$37,599,412	$71,196,141
Overall Savings	$817,502	$2,637,813	$7,423,804	$5,480,499	$2,873,634

Source: DMH State Hospital Expenditure Reports

Although CSH was activated in 2005-06 and accounts for some of the growth in expenditures, the average operating expenditures cost per patient has increased 78 percent or $16,675 in five years, from $21,329 in 2003-04 to $38,004 in 2007-08 (Table 6). As the hospitals fill their vacant positions, salary savings will decrease significantly and may not be able to continue offsetting the operating expenditures deficit.

Table 6: 2003-04 to 2007-08 Operating Expenditures

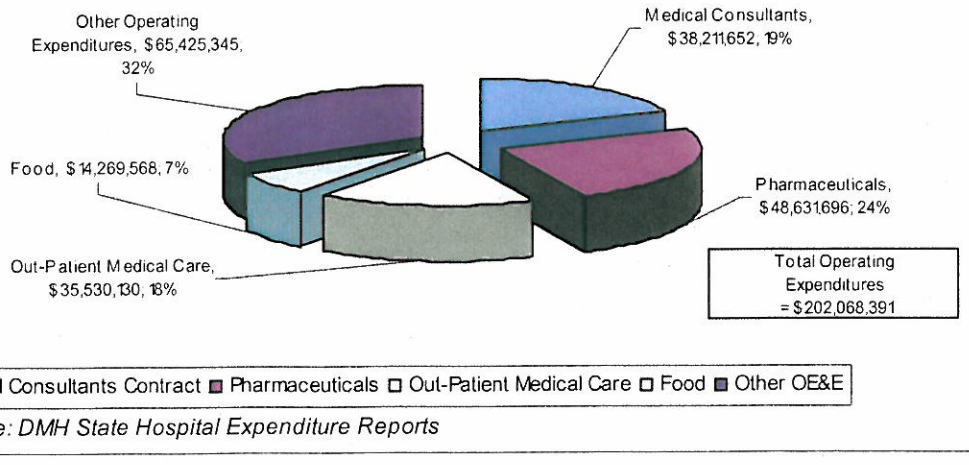


	ASH	CSH	MSH	NSH	PSH	Total	Census at June 30th	Average Per Patient
FY 2003-04	$31,265,274	$0	$16,598,199	$21,317,841	$25,157,792	$94,339,106	4,423	$21,329
FY 2004-05	$39,864,254	$0	$20,821,531	$24,934,854	$33,542,287	$119,162,926	4,907	$24,284
FY 2005-06	$39,833,184	$22,380,435	$18,788,960	$28,723,983	$38,671,382	$148,397,944	5,002	$29,668
FY 2006-07	$48,651,345	$22,443,517	$20,113,200	$32,306,386	$42,033,611	$165,548,059	5,183	$31,941
FY 2007-08	$47,238,393	$34,430,325	$24,918,871	$40,545,564	$54,935,238	$202,068,391	5,317	$38,004

Source: DMH State Hospital Expenditure Reports

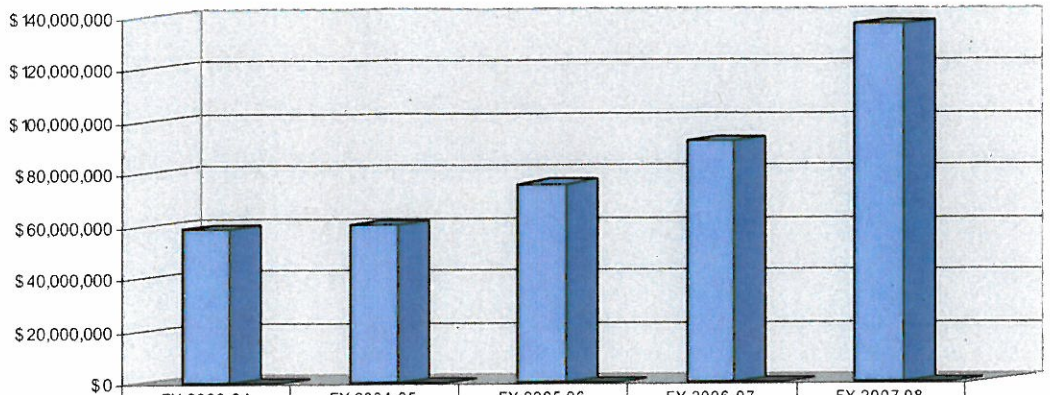
Most of the operating expenditure increases are due to direct patient care. Specifically outpatient medical care, medical consultants, food, and pharmaceuticals are 68 percent of total operating expenditures (Table 7). These patient care costs are generally outside the control of the hospitals and have increased from $58.4 million to $136.6 million for 2003-04 and 2007-08 respectively (Table 8). Average direct patient care operating expenditures has increased 95 percent, from $13,209 (2003-04) to $25,699 (2007-08) (Table 8). The state hospital systems in Pennsylvania and Texas cited some of the same challenges that California is experiencing and were having a difficult time controlling medical and pharmaceutical costs. Moreover, Pennsylvania and Texas had deficits in 2007-08 for their hospitals.

Table 7: 2007-08 Operating Expenditures



Source: DMH State Hospital Expenditure Reports

Table 8: 2003-04 to 2007-08 Medical, Pharmaceuticals, and Food Expenditures



	FY 2003-04	FY 2004-05	FY 2005-06	FY 2006-07	FY 2007-08
Total	$58,425,250	$60,286,165	$75,705,427	$91,743,723	$136,643,046
Average Per Patient	$13,209	$12,286	$15,135	$17,701	$25,699

Source: DMH State Hospital Expenditure Reports

Recommendations:

- A workload study should be conducted by an independent consultant specializing in industry standards and practices to determine the most effective staffing model for the hospitals. The study should address workload shifts to non-LOC staff, LOC staffing ratios, and overtime.

- The DMH is at risk of incurring significant budget deficiencies in the near future. The operating expenditures deficiency continues to grow and the net overall savings continues to decrease (Table 5). It is imperative that DMH, in conjunction with the Department of Finance, Health and Human Services Unit, develop a budgeting mechanism that appropriately funds operating expenditures to prevent future deficiency requests. Other state departments with resident populations maybe experiencing similar issues. A review of these state departments should be included to determine if improvements can be made for statewide contracting of medical services, pharmaceuticals, and food.

APPENDIX A
LEGAL CHALLENGES
INCREASING OPERATING COSTS

Legal Challenges Increasing Operating Costs

1. On May 2, 2006, the United States Department of Justice (USDOJ) and the State of California reached a settlement concerning civil rights violations at four hospitals (ASH, MSH, NSH, and PSH). The extensive reforms required by the five-year Consent Judgment will ensure that individuals in the hospitals are adequately protected from harm and provided adequate services to support their recovery and mental health. The USDOJ conducted its investigation pursuant to CRIPA. DMH is now addressing and correcting the agreed upon violations identified by the USDOJ through the implementation of the CRIPA Enhancement Plan.

2. Enactment of Proposition 83 (Jessica's law)—New Sexually Violent Predator (SVP) law; passed on November 7, 2006. This law increased the program's workload related to screening, evaluation, and housing SVP's. Proposition 83 expanded the definition of an SVP, which makes more sex offenders eligible for an SVP commitment by: (1) reducing from two to one, the number of prior victims to qualify an offender for an SVP commitment and (2) making additional prior offenses "countable" for purposes of an SVP commitment.

The state hospitals had high vacancies in several LOC employee classifications due to a massive exodus of hospital employees to CDCR for higher salaries. In 2007-08, many DMH LOC employee classifications received significant pay increases. The equity pay increases resulting from the Coleman, Plata, and Perez lawsuits were approved to bring DMH LOC classifications within 5 percent parity of similar CDCR classifications.

APPENDIX B
PATIENT CASELOAD PROJECTIONS METHODOLOGY

Patient Caseload Projections Methodology

Each hospital is responsible for taking the patient census by caseload category on a daily basis. The census data is entered into the Admission, Discharge, and Transfer (ADT) system. ADT tracks patient census and patient movements. Headquarters extracts the daily census from ADT to prepare a two-year regression analysis. From the regression analysis, a regression formula is derived and used to project the future patient population at the hospitals.

The regression formula is used to predict all caseloads with the exception of CDCR and LPS patients. CDCR and LPS patient populations are determined by DMH, contracting counties, and CDCR. As a result, the anticipated populations for these patient categories are known.

During this review it was brought to our attention that the current patient projection methodology has been consistent for all patient categories over the past five years with the exception of the SVP commitment category. After Jessica's Law was passed, DMH anticipated a large influx in the SVP patient population and modified the patient projections. In subsequent years, the anticipated SVP growth did not materialize and DMH returned to the regression formula to project the SVP patient population. This issue was reported by the Legislative Analyst's Office in the 2008-09 Analysis of the Budget Bill for Health and Human Services, DMH.

Current year adjustments are used to address prior budget year patient population understatements or overstatements. When preparing the Governor's Budget and the May Revision projections, the actual patient population is compared to prior budget year projections. Adjustments are made to the current year projected population for variances of 2.5 percent or greater.

APPENDIX C
PERSONAL SERVICES
BUDGET ESTIMATION METHODOLOGY

Personal Services Budget Estimation Methodology

DMH's current budgeting methodology for the state hospitals is separated into three categories; non-LOC staff, LOC staff, and operating expenditures. The budget procedures for non-LOC and LOC categories are described in greater detail below.

Non-LOC
Non-LOC employees do not provide direct care to patients. Their primary duties are related to administration, accounting, human resources, maintenance, etc. The work load for non-LOC employees is not directly impacted by changes in the patient population. Changes to non-LOC workloads can occur with new policies implemented by the DMH. Non-LOC positions may be increased through the submission of a Budget Change Proposal (BCP).

LOC
LOC employees are directly involved in providing treatment to patients. These employees include nurses, psychiatrists, social workers, psychiatric technicians, clinical dieticians, and medical doctors. Patient population changes directly impact LOC workload.

DMH uses a two year regression analysis of actual patient census to estimate patient populations. The estimated patient population projection and patient to staff ratios are used to calculate LOC staff required at the hospitals. The ratios are based on licensing regulations, the CRIPA Enhancement Plan, as well as patient acuity levels.

Once the LOC staffing levels have been determined, each hospital is responsible for updating the salaries and wages data. This information is used to prepare the Governor's Budget.

CALIFORNIA DEPARTMENT OF
Mental Health

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David Botelho, Chief
Office of State Audits and Evaluations
California Department of Finance
300 Capital Mall, Suite 801
Sacramento, CA 95814

Dear Mr. Botelho:

The California Department of Mental Health has received the Office of State Audits and Evaluations (OSAE) report on the State Hospital System Budget Estimate Audit. The department agrees with the findings presented in this report and agrees with the methodology utilized by the Department of Finance to evaluate the state hospitals budgeting and allocation methodology.

The report reflects the department's methodology in estimating patient caseload and operating expense and equipment. Several of the recommendations presented in the report have the potential to improve the department's methodology for estimating operating expenditures and improve the existing staffing models. The department will research the recommendations for future implementation into the budgeting methodology for the state hospitals.

Currently, the department has incorporated OSAE's recommendation to include Coalinga State Hospital operating expenditures into operating expense and equipment regression estimate. Furthermore, these recommendations would facilitate the state hospitals in meeting the goals of the Civil Rights of Institutionalized Persons Act (CRIPA) enhancement plan.

On behalf of the California Department of Mental Health, thank you for this important review of the state hospitals budgeting and allocation methodology. We are also appreciative of your continued support to help us improve the management, accountability, effectiveness, and efficiencies of our department through the professionalism and expertise provided by your staff.

Sincerely,

STEPHEN W. MAYBERG, Ph.D
Director

cc: Ms. Elaine Bush, Chief Deputy Director, California Department of Mental Health
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Mr. Stan Bajorin, Deputy Director, Administration, California Department of Mental Health
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